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DEVELOPMENT OF A GYNECOLOGIC ASSESSMENT INSTRUMENT BASED ON THE SHULER NURSE PRACTITIONER PRACTICE MODEL

by
Patricia L. Dykstra
B.S.N., University of Central Florida, 1985

Submitted to the School of Nursing
and the Faculty of the Graduate
School of the University of Kansas
in partial fulfillment of the
requirements for the degree of
Master of Science.

Barbara Lathrop Hughes
Faculty Advisor

11/15/85
Date Project Accepted

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Summary

Lesbians frequently encounter dilemmas in seeking appropriate health care. If a lesbian chooses to disclose her sexual orientation, she risks potential homophobic reactions such as ridicule, embarrassment, and antagonism. Although homophobia is the principle barrier for lesbians seeking appropriate health care, heterosexism, the assumption people are heterosexual unless otherwise stated, is also a prevalent barrier. Usually, a lesbian initially encounters heterosexism in the language of the health history form.

The purpose of this research project was to develop a gynecologic assessment instrument, based on the Shuler Nurse Practitioner Practice Model, that was sensitive to sexual orientation. This author designed the Nurse Practitioner Gynecologic Assessment Instrument to guide nurse practitioners in performing gynecologic examinations. Part A is a health history intake form. Recommendations from multiple sources were used to guard against heterosexist bias. Part B is an operationalization of the Shuler Nurse Practitioner Practice Model. Through an evaluation of the health status, the nurse practitioner, in conjunction with the patient, develops a plan of care.

The data collected in this project was for the purpose of establishing content validity of the Nurse Practitioner Gynecologic Assessment Instrument. A panel of seven nurse experts participated in this initial effort to establish content validity. The panel evaluated the instrument as sensitive to sexual orientation and reflective of the Shuler Nurse Practitioner Practice Model.

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Chapter I

Introduction

To validate the diversity in human sexual behavior and expression, the psychological community developed the term sexual orientation. Sexual orientation refers to the "sexual and affectional relationships of lesbian, gay, bisexual, and heterosexual people" (American Psychological Association, 1991, p. 973). Currently, the terms gay male sexual orientation and lesbian sexual orientation are preferable to the term homosexuality, for the former terms focus on the individual; the latter term has historical associations with criminal behavior and pathology (American Psychological Association, 1991). In specifically identifying a lesbian sexual orientation, the American Psychological Association (1991) hoped to decrease the negative stereotyping and ambiguity lesbians face in asserting themselves as individuals in society. The statistics reflect this problem. Although it is widely accepted that lesbians constitute 10% of the female population, this statistic probably underestimates the true numbers (Lynch, 1993; Zeidenstein, 1990). The "invisible minority" (Hitchcock & Wilson, p. 178) of lesbians blames this underestimation on societal homophobia. Homophobia, the "irrational fear, dislike, or hatred of lesbians and gay men" (Zeidenstein, p. 10), creates a hostile environment that inhibits lesbians from freely reporting their sexual orientation. For lesbians, public disclosure of sexual orientation is a risk (Hitchcock & Wilson, 1992). They risk antagonism, intimidation, rejection, ridicule, and injury (Stevens, 1994).

In order to provide quality women's health and primary care, accurate information pertaining to a woman's sexual orientation is important (Robertson, 1992). If a health care provider does not ascertain a lesbian's sexual orientation during the assessment process, the provider may erroneously focus on issues that are not applicable to lesbians, such as contraception (Stevens, 1995). Furthermore, delay in appropriate diagnosis and alienation from important health promotion and disease

prevention messages can occur if the sexual orientation of the patient is not disclosed (Lyon-Martin, 1992; Stevens, 1995). Unfortunately, lesbians are reticent in disclosing their sexual orientation for fear of negative reactions from their health care providers (Harvey, Carr, & Bernheine,1989; Stevens, 1992). Homophobia is still present in health care. Studies have established homophobia as a major barrier to the provision of appropriate health care for lesbians (Smith, Heaton, & Seiver, 1990; Zeidenstein, 1990). Through education, though, many health care facilities and professional organizations have developed programs to address the issue of homophobia in the health profession. For example, the Royal College of Nurses, the British equivalent of the American Nurses' Association, offers periodic workshops that enable participants to explore the issues and to express the experiences of caring for lesbians and gay men (Rose & Platzer, 1993).

Although homophobia is the principle barrier in disclosure of sexual orientation, it is not the only barrier. Heterosexism, the assumption people are heterosexual unless otherwise stated, is prevalent in the health care profession (Bernhard & Dan, 1986; Robertson, 1992; Stevens & Hall, 1988). As opposed to the overt negativism of homophobia, heterosexism is a covert value system. According to Robertson (1992), many people who disdain homophobia and claim to be unprejudiced toward lesbians and gay men, are unconsciously heterosexist. When the health care provider assumes a client is heterosexual, the burden is on the lesbian client to disclose orientation or to pass as a heterosexual (Lynch, 1993). In Women's Health, heterosexism is initially displayed in the language of the health history questionnaire. Lesbians deal with questions of contraception, sexual activity, reproduction, parenting, and marital status from a heterosexual viewpoint. Heterosexist questionnaires force lesbians to either leave questions blank, write long explanations of why questions do not apply, or, if they are uncomfortable about disclosing, answer as a heterosexual (Stevens, 1994). The

lesbian answers the heterosexist questions based on her stage of sexual identity and her perception of a homophobic environment. Depending on how the lesbian answers the questionnaire, the health care provider may continue asking heterosexist questions in the provider-client interview.

If a lesbian feels she can not disclose her sexual orientation to the provider, the provider can not render appropriate care. The provider not only could misdiagnose, such as diagnosing ectopic pregnancy when it is pelvic inflammatory disease, but also miss the psychosocial, cultural, and spiritual dynamics of the lesbian (Lynch, 1993; Rose & Platzer, 1993). So, it is not enough for providers to confront their homophobic attitudes, but they also need to evaluate their heterosexist attitudes in order to provide all females optimal care (Gentry, 1992). One important area to evaluate for heterosexism is the gynecologic assessment instrument.

Statement of the Problem

Standard gynecologic assessment instruments are designed upon the assumption of heterosexual orientation. This may preclude a lesbian from disclosing her sexual orientation. If sexual orientation is not disclosed, the health care provider can not render sensitive and appropriate care. A gynecologic assessment instrument cognizant of sexual orientation needs to be developed to assist health care providers in delivering optimal care.

Purpose of Research Project

The purpose of this research project is to construct a gynecologic assessment instrument designed for nurse practitioners to promote health care that is sensitive to sexual orientation. The instrument uses the Shuler Nurse Practitioner Model as a basis for instrument development.

Chapter II

Review of Literature

The objective of this literature review is to increase the understanding of lesbians and their dilemmas in seeking appropriate health care. Nurse practitioners need this information to eliminate heterosexist bias from communications with clients. The first section of this chapter explores lesbianism as a concept. The second section examines relevant research pertaining to lesbian health care experiences. The third section reviews the Shuler Nurse Practitioner Practice Model.

Theoretical Literature

"Sexuality is a broad concept that encompasses the dimensions of sexual desire, sexual response, view of self, and presentation of self" (Fogel, 1994, p. 61). Sexual orientation, as stated earlier, specifically refers to the sexual and affectional relationships of people (American Psychological Association, 1991). Heterosexuality, bisexuality, and homosexuality encompass the categories of sexual orientation. According to Webster's Comprehensive Dictionary (1986), homosexuality is "sexual attraction for . . . . relations with a person of the same sex" (p. 605), and lesbianism is "homosexuality among women" (p. 731). Browning (1984) believed this definition primitively explained the concept of lesbianism. She contended that if lesbianism was defined in a purely sexual context, it would be impossible to accurately measure the true membership of this population. To validate this argument, she explained that some women who engage in sexual activity with other women do not regard themselves as lesbian. These women acknowledge a heterosexual or bisexual ideology. Both these concepts encompass different value systems from lesbianism. Conversely, a woman who has never and does not intend to engage in sexual activity with another woman, may consider herself a lesbian.

Browning (1984) developed a construct of lesbian identity to enrich and clarify the

phenomenon. Her definition encompassed social, emotional, affectional, and political issues facing lesbians, as well as their sexual behavior (Zeidenstein, 1990). As Troiden (1988) described, identification as a lesbian is a developmental process. The process of identification is highly individualized and fluid. Environmental, cultural, social, and psychological elements also contribute to the level of identification. The following is a summary of Troiden's (1988) four-stage model of homosexual identity development:

1. Sensitization: An awareness of individuals of the same sex usually occurs before puberty. At this stage, a child would not identify herself as lesbian but would perceive herself as different from her peers.
2. Identity Confusion: When an adolescent begins to realize that she may be lesbian, stress and inner turmoil may occur. Adolescents usually find it difficult to discuss lesbianism, especially in a homophobic environment. Responses to this identity confusion include denial of feelings, avoidance of situations that might increase their lesbian feelings, rationalization of their behavior as a phase, and immersion into the heterosexual culture. Some accept themselves as lesbian and seek resources and support. Others stagnate in this stage for months, years, or forever.
3. Identity Assumption: For lesbians, this stage commonly transpires between 21 and 23 years of age. She adopts the lesbian identity and confides her identity to empathetic others. Lesbians usually assume the identity after an ardent relationship with another woman. The woman may deal with societal stigma by avoiding lesbian activity, becoming involved in the lesbian community, or concealing sexual orientation and leading a double life.
4. Commitment: During this stage, it becomes easier to live as a lesbian and enter into love relationships. Internally, it is validation and satisfaction with the lesbian identity. Externally, it is the confidence of disclosing the lesbian identity

to others who are not homosexual.

Conveying a succinct depiction of the lesbian identity is difficult, for lesbians are a diverse population (Stevens, 1994). Furthermore, establishing the tenets of the lesbian culture is, at best, a tenuous exercise. According to Card (1995), culture is defined as "the behaviors and beliefs characteristic of a particular social, ethnic, or age group . . . . the sum total of ways of living built up by a group of human beings and transmitted from one generation to another" (p. 12). She stated lesbians are not one social group but many social groups. Ferguson (1991) debated the validity of labeling the lesbian population as a culture. She wondered if all the groups of lesbians embraced a common language, value system, habits, rituals, and philosophy exclusive to itself and practiced by all members.

To judge by historical records, lesbians have seldom had such group cohesiveness to develop a unified culture (Card, 1995). Customs, vocabularies, and symbols indigenous to one lesbian group rarely transcend to other groups. Ferguson (1991) further noted that speaking of the lesbian culture as a unified social group is misleading, for many individuals who contributed to the lesbian ideology were not lesbian. For example, although many of the founders of the feminist movement are heterosexual, the movement emboldened the lesbian population to establish their equality in society (Noddings, 1989). So, attempting to concisely define lesbianism is subject to misrepresentation. In this context, the development of the following subconcepts of lesbianism is made with the following disclaimer: These subconcepts are broad generalizations not intended to stereotype or misrepresent but to form a foundation for further inquiry. The subconcepts explored are based on Browning's (1984) components of the lesbian identity.

Social

According to The Random House Dictionary of the English Language (1969),

social is defined as "devoted to or characterized by friendly companionship or relations . . . . Living or disposed to live in companionship with others in a community, rather than in isolation" (p.1247). The "social construction" (Kitzenger, 1987, p. 153) of lesbianism is a product of both current societal norms and lesbian ideology. Historically, lesbianism had been a fully accepted manner of life (Falco, 1991). Furthermore, in some societies, it had been revered with special status and privileges. However, Western societal views of lesbianism range from considering it a moral-theological dilemma to a medical-psychological disease (Grahn, 1984). Homophobia, a "socially sanctioned hatred"(Card, 1995, p. 154), has contributed to the development of lesbian social patterns. Actually, it is not so much the fear of public condemnation associated with homophobia, but the concept of homophobia as the "weapon of the patriarchy" (Pharr,1988, p. 9) which has shaped lesbian social patterns. Purist lesbian ideology rejects the attributes of male oriented societal norms, such as control and power, in favor of female oriented norms such as nurturing and consensus (Card, 1995). In this light, the manifestation of lesbian social construction is formed.

Currently three recognized lesbian social patterns exist in western society: dissociation from the world, assimilation into the world, and victimism in the world (Raymond, 1986). Dissociation is withdrawing from the perceived heterosexist society (Hoagland, 1988). Lesbians who dissociate actively separate from the male-dominant society and male-oriented norms, in favor of exclusive interactions with ideologically compatible women. This is manifested by the creation of lesbian communities (discussed later in this section). Not all lesbians living in a lesbian community are dissociated; some choose to assimilate. Arendt (1978) states assimilation is interacting in society while maintaining the tenets of a particular culture. No matter their geographical location (ie., living in a lesbian community or living autonomously), lesbians who assimilate actively engage in society to obtain a better understanding of

the outside world in order to promote the advancement of lesbianism. Not all lesbians who live autonomously can assimilate. Sadly, those who can not reconcile their lesbian identity become victims. Raymond states victims live in a closet, are immobilized, and are cut off from other lesbians.

Lesbians who choose to dissociate or assimilate usually form elaborate kinship networks among themselves (Heffernan, 1972). Women who erotically bond with each other may adopt one another's friends as mothers, fathers, sisters or brothers. These networks are complete with kinship boundaries and prohibitions against erotic intimacy. These families provide counsel and support to members in crises, provide socialization new members, and offer stability. These kinship networks are very strong, for, as Heffernan (1972) states, "couples may come and go, but families remain" (p. 88). These kinships may generate stronger friendship than birth families, for kinships are chosen, not inherited.

Those in a kinship network may choose to interact with other kinship networks, called a social network; the collaboration of social networks creates a lesbian community (Wolf, 1979). Although the social networks associate with each other in the community, lesbians tend to mainly interact with their own social network. But, participation in a community is fluid. Wolf (1979) admits that inclusion into another social network, because of a new lover, is a relatively easy process. The lesbian may keep up with individuals from her old group, but her loyalties will be directed toward the new network. Thus, new configurations are constantly developing in the social network system of the community.

Egalitarianism in the community is an important tenet of lesbian ideology (Wolf, 1979). Theoretically, social structure does not exist in communities. By its nature, social structure is based on hierarchical distinctions, a male-oriented norm. In fact, the structure of the community is a series of overlapping social networks, in which friendship

groups focus around pair relationships or special interests. Women who are more active in community projects are usually more widely known and may have greater prestige, but members are reticent to call these active lesbians leaders of the community. Within the social networks, women with stronger personalities tend to influence their own groups, but a conscious effort exists in maintaining consensus in decision-making.

Emotional

Many factors impact the emotional development of the lesbian. This section will only explore one--internalized homophobia. To one degree or another, anti-homosexual attitudes permeate the psyche of those individuals who live in an unaccepting society (Falco, 1991). Even before initiating the process of lesbian identification, the "future lesbian" (Falco, p. 71) was probably engendered with heterosexual values and exposed to negative homosexual stereotyping. The impact of these attitudes on the lesbian range from inconsequential to profound. A specific cause for the range of this effect is unknown, but researchers speculate certain factors contribute to the impact. Falco states these factors include age of exposure to information, the source of the information, and the individual's predilection to internalize information. Internalized homophobia is a protective mechanism against the fear of becoming a homosexual and the "fear of defenseless exposure to socially tolerated and institutionally sanctioned hostility" (Card, 1995, p. 160). Margolies, Becker, and Jackson-Brewer (1987) identified manifestations of internalized homosexuality: (a) protection against discovery, (b) discomfort with overt homosexual exhibition, (c) rejection of all heterosexuals (heterophobia), (d) perception of superiority to heterosexuals, (e) rationalization of similarity between lesbians and heterosexual women, (f) uneasiness with lesbian parenting, and (g) avoidance of relationships. Inability to overcome internalized homophobia may lead to ineffective emotional

expressions (Card, 1995). Overcoming internalized homophobia is a principle component to achieving a complete lesbian identity.

Affectional

Theoretically, a healthy lesbian relationship is based on the lesbian-feminist tenet of equality (Schneider, 1986). As opposed to traditional heterosexual relationships, the power differential is equalized in a healthy lesbian relationship (Johnson, 1991). The majority of lesbian couples appear to make an effort to share their resources, household chores, decision-making, living and recreational expenses either equally or according to a mutually agreed upon system (Falco, 1991). The theoretically healthy lesbian relationship symbolizes an adult intimacy based on mutual love and support. According to Clunis and Green (1988), the lesbian couple must proceed through a predictable developmental process before obtaining this idealized relationship. The stages of development are:

1. Prerelationship: Lesbians may rely more on intuition than on direct communication when evaluating a potential relationship. Although women's intuition is usually more sophisticated than men's intuition, primarily using intuition may lead to misunderstandings. To avoid misunderstandings, lesbians should verbalize their needs, wants, desires and expectations early in the relationship.
2. Romance: Lesbian relationships are particularly intense, for women are socialized to nurture. The danger in such closeness is the potential for the two lesbians to merge, "the tendency for two people to be as close together as physically and psychically possible" (Falco, 1991, p. 109), and lose their individuality. To guard against merging, lesbian couples must take the time to get to know each other, to understand differences exist, and to encourage individuality in the relationship.

3. Conflict: Women usually resolve conflict by placing priority on maintaining the relationship, assessing the needs and vulnerabilities of the individuals involved, and seeking a solution that will do the least harm to those most in need (Gilligan, 1982). Lesbian couples may resolve their conflicts by yielding to the most needy in the relationship. On the positive side, this style of conflict resolution encourages the couple to stay together during conflicts. But, on the negative side, one or both parties may be too prone to sacrifice her own needs for the other. Lesbians must develop conflict resolution mechanisms that respects both individual's needs.

4. Acceptance: This stage is a period of stability, deep affection, and respect for differences. Merging and individuality strike a balance.

5. Commitment: If the lesbian couple experiences a lack of social support, they may experience anxiety over commitment (Johnson, 1991). Compounding this, legal expression of commitment, such as marriage, does not exist. The lesbian couple must overcome these barriers in order to make a long-term commitment.

6. Collaboration: The couple reexperiences all the prior stages when dealing with important issues, such as parenting. The couple may redefine the relationship as they rework the previous stages.

Affectional relationships with lesbians include friendships. Friendships between lesbians may affect the relationship with their lover differently than friendships between heterosexual women (Falco, 1991). In lesbian friendships, every woman could be a potential lover, whereas in heterosexual relationships, friends of one's own gender are not only non threatening, but expected. Also, in heterosexual relationships, women friends can embrace, touch, and regard each other warmly without such behavior having romantic implications. When lesbians are affectionate with their non-lover

friends, boundaries for the relationship become hazy (Sang, 1984). Further, many lesbian relationships begin as non-romantic friendships, increasing the threat that what is now a friendship may have the potential of damaging the couple relationship. Even with this potential problem, it is important for lesbians to have women friends as well as lovers.

Political

The random house dictionary (1969), defines politics as "use of strategy or intrigue in obtaining any position of power and control" (p. 1027). For lesbians, political awareness is a dichotomy (Card, 1995). As the invisible minority, they want to legitimize their ideology in this society. Obtaining a voice in this society requires the power to manipulate. This is paradoxical to the basic lesbian-feminist ideology they espouse. The basic tenet of lesbian-feminist ideology is egalitarianism unfettered by the male-dominant norms of power and control. Reconciling this dichotomy has created diversity in lesbian political expression. Lesbian politics ranges from conservative to radical (Kitzenger, 1991). To some extent, all lesbians are political, for they are trying to obtain a voice in a homophobic society.

Relevant Research

Stevens and Hall (1988) lamented on the paucity of research regarding lesbian health care. They stated this deficiency promotes the provision of health care based on myth and intuition rather than on empirical knowledge. Fortunately, studies concerning lesbian health care needs have increased. But many of these studies concentrate on the morbidity of lesbians. For example, a large body of knowledge has been accrued on the incidence of alcohol abuse in the lesbian population (Bloomfield, 1993; Bradford, Caitlin, & Rothblum, 1994; Savin-Williams, 1994; Trippet, 1994). These studies are important in the provision of empirically based health care, but more studies addressing the experiences lesbians face in accessing health care is needed. Without this type of

research, the perpetuation of homophobic and heterosexist attitudes in the delivery of health care will continue (Buenting, 1992). This section focuses on the research available concerning the experiences lesbians have in accessing health care.

All of the available research on lesbian experiences were qualitative in design. This lends credence to the notion that the relationship between the lesbian and the health care system is complex (Gentry, 1992). Not surprising, a major theme in these studies is the issue of disclosing sexual orientation. Hitchcock and Wilson (1992) performed a theory-generating study on the disclosure of sexual orientation to health care providers. Through grounded research, Hitchcock and Wilson (1992) developed the Theory of Personal Risking; a social process lesbians employ to determine a disclosure posture. The authors interviewed 33 self-identified lesbians and used constant comparative analysis to derive the core concepts of the theory.

In the anticipatory phase, the lesbian determines the risk of self disclosure by using imagined scenarios of the particular health care setting and cognitive strategies. Cognitive strategies included formalizing lesbian relationships through obtaining a power of attorney and screening providers for their acceptance of lesbian orientation. The interactional phase begins in the health care setting. Lesbians use scanning strategies prior to disclosure to determine the safety of the environment. Once the disclosure has been implemented, the lesbian continuously observes the responses of the health care provider in a process called monitoring.

Stevens and Hall (1988) described lesbians' experiences with health care providers. A semi-structured interview with 25 self-identified lesbians revealed 72% of the participants experienced negative responses from the health care provider after disclosure of sexual orientation. Responses of the health care provider included embarrassment, condescension, fear, and unfriendliness. Furthermore, 36% of the participants described circumstances in which they abruptly terminated the encounter or

did not return because of the provider's response following the disclosure. Interactions involving gynecologic health care were of particular distress to these lesbians. Questions asked by the provider assumed heterosexual orientation. "Overwhelmingly, participants found that there was no routine, comfortable way to let health care providers know that heterosexual assumptions were not applicable to them as lesbians" (Stevens & Hall, p. 72).

Stevens (1994) performed a feminist narrative study to explore lesbian's experiences with health care. Thirty-two lesbians, of varying socioeconomic and ethnic backgrounds, recounted their actions and reactions to the experience . Through data analysis, the author developed a repertoire of strategies lesbians used when health care was needed. The strategies were: (a) rallying support--eliciting guidance, information, and tangible support from lesbian friends in lieu of or prior to contacting professional health care; (b) screening providers--determining the level of homophobic attitudes of the health care provider; (c) seeking mirrors of one's own experience--finding health care providers who were lesbian or lesbian affirmative; (d) maintaining vigilance--constantly monitoring for subtle cues of homophobic or heterosexist attitudes; (e) controlling information--withholding sexual orientation if environment appeared to be homophobic or heterosexist; (f) bringing a witness--bringing a trusted friend to the health care encounter to act as a safeguard and witness; (g) challenging mistreatment--voicing dissatisfaction with inappropriate care; and (h) escaping danger--abruptly departing from a threatening health care encounter. From this analysis, Stevens emphasized the need for holistic, empathetic nursing care to promote a safe environment for lesbians.

Robertson (1992) also described the health care experiences of lesbians. Using the grounded theory approach, the author interviewed ten self-identified lesbians. The data analysis revealed five themes that contributed to the experience: (a) assumption of heterosexuality--questions from the health history form and health care provider were

not pertinent to lesbian orientation; (b) coming out--health care provider reactions ranged from "fine" to "taken aback"; (c) expectations--lesbians desired competent empathetic health care from their providers; and (d) health-care seeking behavior--harassment and financial issues were barriers to seeking routine health care. From this data analysis, the author emphasized the need for health care providers to recognize the special concerns lesbians face in accessing health care.

One study investigated the experiences of lesbians in a specific health care area. Hall (1994) described the encounters of 35 self-identified lesbians in alcohol recovery. Through an ethnographic study, the author developed three themes that were barriers in recovery-related healthcare interactions. First, clients' trust of providers depended upon the provider's efforts to understand and support the clients' sexual orientation. All participants cited providers' heterosexual assumptions, ignorance of the lesbian culture, and negative social responses as sources of their mistrust in the providers. Second, provider-client conceptual congruence was defined as the level of harmony between the lesbian and provider's perceptions of problems and appropriate interventions. Lesbians perceived a dichotomy between their view of the origins of their alcoholic problems and the providers' views. The providers usually contributed the clients' alcoholic problem to lesbianism and disregarded other possible causes. Third, providers' persuasive styles was defined as pressure, inducement, and ultimatums used to shape client behavior or induce client decision-making regarding alcohol problems. Although these styles were used to facilitate the development of coping skills, often they had an opposite effect.

The Shuler Nurse Practitioner Practice Model

The Shuler Nurse Practitioner Practice Model provides a viable framework for developing a gynecologic instrument that is cognizant of lesbian orientation (see Appendix A). Shuler and Davis (1993a, 1993b) developed the model to alleviate the dilemma nurse practitioners face in applying traditional nursing theories to clinical

practice and to increase the theoretical foundation of the nurse practitioner profession. Although the Shuler Nurse Practitioner Practice Model has direct clinical application, it displays the attributes of a theoretical model. According to McFarlane (1976), a theoretical model must be based on nursing research and scientifically supported generalizations, and it must lend itself to testing through the development of hypotheses.

As with other theoretical nursing models, Shuler & Davis (1993a, 1993b) integrated their conceptualization of person, health, nursing, and environment into the Shuler Nurse Practitioner Practice Model. In addition, they added a fifth concept--the Nurse Practitioner role. Interestingly, the authors have openly invited the readers to modify the model with their own definitions of the concepts. This declaration not only empowers the nurse practitioner, but it also increases the accessibility and applicability of the model. The following is a summary of the five fundamental concepts:

Person: According to Bertalanffy (1968) and Roy (1970), person is a wholistic concept composed of physiological, psychological, social, cultural, and spiritual elements. The person is an adaptive system that interacts with a constantly changing environment to maintain balance. Individuals have the ability and freedom to choose how they will adapt. In health care, individuals have the right to accept or reject health care, for they are ultimately responsible for their health. NPs should promote an empowered relationship, so individuals can become active participants in the health care process.

Health: Health is a dynamic and continuous process that incorporates the physiological, psychological, social, cultural, and spiritual elements of an individual. Wellness, illness, disease prevention, health promotion, self-care, rehabilitation, and education are processes integral to health.

Nursing: The concept of nursing encompasses the profession and the process. As members of the health care profession, the nurse employs a scientifically based,

interpersonal process in response to human reaction to actual or potential health problems and in the promotion of wellness.

Nurse Practitioner Role: The nurse practitioner exhibits expert nursing and medical skills. "The NP serves as a facilitator who assists patients toward restoration and wellness through nursing and medical interventions, self-care, health promotion, disease prevention, and wellness activities" (Shuler & Davis, 1993a, p.16).

Environment: Individuals' health status is closely associated with their environment. The environment is dynamic; it modifies individuals and it is modified by individuals.

The composition of the model is based on General System Theory (Bertalanffy, 1968). The interaction between the nurse practitioner and the patient constitutes the input into the system. The nurse practitioner not only assesses the health status of the patient, but how the physiological, psychological, social, cultural, and spiritual elements of an individual impact the health status. In this phase, the nurse practitioner invites the patient to be an active participant in the encounter. The model encourages an empowered nurse practitioner-patient relationship through this partnership. In the throughputs stage, the nurse practitioner and patient develop a diagnosis and plan of care that is mutually agreeable. Because a system is dynamic, a change in one of the elements must be proceeded by a change in the other elements to maintain balance. So, both the nurse practitioner and the patient should reflect a change in the outputs of this system.

Although only one published study using the Shuler Nurse Practitioner Practice Model as the conceptual framework exists in the literature, it demonstrates the model's validity for application in research and practice. Shuler, Gelberg, and Brown (1994) conducted a retrospective study to explore fifty homeless women's family planning needs. The study examined the relationship between two aspects of the Shuler Nurse

Practitioner Practice Model: spiritual/religious practices and psychological status. The authors found 48% of the sampled women reported the use of prayer significantly related to less use of alcohol and street drugs, fewer perceived worries, and fewer depressive symptoms.

This model is applicable in the development of a lesbian sensitive gynecologic assessment instrument, for it promotes an empowered nurse practitioner-client relationship and validates the importance of assessing the elements that constitute the lesbian identity.

Summary

Lesbianism is a complex concept encompassing the social, emotional affectional, political, and intellectual issues facing woman who are sexually attracted to other women. This complexity extends to their experiences of accessing the health care system. A few qualitative studies indicate the problems lesbians encounter. Disclosure of sexual orientation and assumptions of heterosexuality are recurrent themes throughout these studies. Due to their qualitative design, their findings can not be inferred to the total population of lesbians. Although these studies are not generalizable, it is clear health care providers need to initiate steps to assure the health care encounter is not entrenched in homophobic and heterosexist bias. Analyzing the health history questionnaire is an initial step in decreasing this bias. The Shuler Nurse Practitioner Practice Model is an appropriate framework for developing a gynecologic instrument that is sensitive to sexual orientation.

Chapter III

Development of Instrument

Formulation of Objectives

This project was implemented to accomplish the following objectives:

1. Develop a gynecologic assessment instrument for nurse practitioners that is sensitive to sexual orientation.
2. Develop content validity of the instrument through review by nurse practitioner experts, nurses expert in instrument development, and nurses expert in lesbian health care.

Instrumentation

Written documentation of permission was obtained from Dr. Shuler before development of the instrument was initiated (see Appendix B). Part A of the Nurse Practitioner Gynecologic Assessment Instrument is a health history questionnaire (see Appendix C). It is a thorough recount of past medical/social history and current health status. The format is based on Bate's (1991) content of comprehensive history. Also, vignettes from the American Psychological Association (1991), Gentry (1992), Lynch (1993), and Zeidenstein (1990) were used to guard against heterosexist bias in language. For example, the American Psychological Association (1991) recommends incorporating sexual terminology that is applicable to all sexual orientations (e.g., use the term "sexual activity" instead of "sexual intercourse"). Lynch (1993) suggests that the provider should specifically ask the patient the gender of their partner or partners. Gentry (1992) recommends including " a category for 'committed relationship' or 'gay/lesbian couple' on the marital status portion of the health history form" (p. 176). Although disclosure of sexual orientation is important, Zeidenstein (1990) expressed one caveat to disclosure; some lesbians prefer that their sexual orientation not be recorded in the medical record.

Part B of the Nurse Practitioner Gynecologic Assessment Instrument is an operationalization of the Shuler Nurse Practitioner Practice Model. The section entitled "Subjective Data Gathering" offers the provider an opportunity to wholistically assess the patient. The provider evaluates the health status by synthesizing physiological, psychological, cultural, environmental, and spiritual aspects of the patient. After the objective data gathering is accomplished, the nurse practitioner develops a diagnosis based on the unique combination of needs, factors and problems the patient may display and validates this diagnosis through the patients input. The provider and patient develop a plan of care that enables the patient to take an active role in the management of their care. The provider contracts with the patient to assure the patient understands and agrees with the diagnosis and plan of care. A follow-up to obtain feedback on the effectiveness of the nurse practitioner-patient interaction and to see if modification of the treatment plan is also determined.

Instrument Validation

Once the initial construction of the instrument was completed, the instrument was analyzed for validity (Waltz, Strickland, & Lenz, 1991). Validity of an instrument describes how well the instrument measures what it claims to measure (Burns & Grove, 1993). When an instrument is valid, it reflects the concept it was intended to measure. According to Burns and Grove three primary types of instrument validity exist: content validity, predictive validity, and construct validity. For the purposes of this project, only content validity will be discussed.

Content validity reflects how appropriate and how representative the instrument items are. Evidence of validity is obtained through literature analysis and review by a panel of experts (Burns & Grove, 1993). Content is considered at the item and test levels (Waltz, Strickland, & Lenz, 1991). Item-content validity is the extent to which each item is a measure of the content domain--"the universe . . . of the construct" (Burns &

Grove, 1993, p. 344). At the total test level, content validity relates to the "representativeness of the total collection of test items or tasks as a measure of content domain" (Waltz, Strickland, & Lenz, 1991, p. 238). Due to the design of the Nurse Practitioner Gynecologic Assessment Instrument, content validity was evaluated only at the total test level.

A panel of experts was asked to judge the instrument for content validity (Burns & Grove, 1993). The judges must be given "specific directions for making judgments, as well as specifications of what they are judging" (Kerlinger, 1973, p. 459). Specific guidelines are directed toward the appropriateness, accuracy, and representativeness of the instrument. Lynn (1986) recommends selection of at least five experts. However, if location of of expertise is difficult, a minimum of three experts is acceptable.

Definition of Relevant Terms

Lesbian: "a woman whose primary emotional, psychological, social and sexual interests are directed toward other women" (Kingdon, 1979, p. 44).

Heterosexist Bias in Language: "perpetrating demeaning attitudes and biased assumptions about (homosexual) people in their writing" (APA, 1994, p. 46).

Content Validity: "relates to how well the content of a test or measure matches the objective to be measured" (Waltz, Strickland, & Lenz, 1991, p. 238).

Nurse Practitioner Role: "focus on evaluating total (wholistic patient needs with patient input while providing episodic, as well as comprehensive care" (Shuler & Davis, 1993a, p. 12).

Identification of Assumptions

The assumptions about lesbians are:

1. Lesbians will not disclose their sexual orientation to nurse practitioners unless they perceive a safe environment or unless emergency conditions exist.
2. Lesbians are less likely to disclose their sexual orientation if they perceive

heterosexist bias in language on the health history questionnaire.

The assumptions adapted from the Shuler Nurse Practitioner Practice Model are:

1. People are wholistic beings.
2. The nurse practitioner and patient are partners in health care.
3. The patient is an active participant in the partnership.

The assumptions about instrument validation are:

1. Content experts honestly critiqued the instrument.
2. Content experts were either knowledgeable about heterosexist bias, the nurse practitioner role, or instrument development.

Chapter IV

Methods and Procedures

The purpose of this research project was to develop a gynecologic assessment instrument for nurse practitioners that is sensitive to sexual orientation. This chapter includes the data collection procedure.

Data Collection Procedure

A panel of seven nurse experts was selected to participate in the process of establishing content validity of the Nurse Practitioner Gynecologic Assessment Instrument. Inclusion criteria for selection was based on the nurse's expertise as a nurse practitioner, in instrument development, or in lesbian health issues. Permission to dispense information about participation in instrument validation was obtained through contacting the nurse experts either personally or by telephone. Of the seven nurse experts, five were known to the author; two were contacted based on recommendations from reputable sources.

The nurse experts were given a package that included a cover letter requesting a critique of the instrument (see Appendix D), the critique questionnaire for content validity (see Appendix E), a demographic form (Appendix F), and the Nurse Practitioner Gynecologic Assessment Instrument. The package also included the two journal articles explaining the Shuler Nurse Practitioner Practice Model (Shuler & Davis, 1993a, 1993b) and the American Psychological Associations (1991) journal article on avoiding heterosexual bias in language. A return postage-paid envelope was provided for returning the critique questionnaire and demographic form. Data collection took place during the months of August and September, 1995.

The critique questionnaire consisted of seven questions. Descriptors on the questionnaire included completeness, sensitivity to sexual orientation, integration of the Shuler Nurse Practitioner Practice Model, and clarity of the instrument. Five of the

question were rated responses on a 5-point Likert scale ranging from 1 (not at all) to 5 (very much).

Chapter V

Analysis of Data

This chapter describes the initial efforts of establishing content validity for the Nurse Practitioner Gynecologic Assessment Instrument. The first section is a demographic description of the nurse experts. The second section includes the results of the experts' critique.

Description of Experts

Seven nurse experts agreed to participate as evaluators to establish content validity of the instrument; all of the nurses completed and returned the critique and demographic questionnaires. One of the nurses also returned the Nurse Practitioner Gynecologic Assessment Instrument with additional recommendations written on it. All of the nurse experts were women and had experience in Women's Health. Two of the nurses were from one large Midwestern metropolitan area, one was from a large Midwestern metropolitan area but at a different location from the first two nurses, one was from a moderate size Midwestern city, two were from one Midwestern rural community, and one was from a rural eastern community.

Table 1 depicts the nurses' present employment position, level of nursing education, total years of nursing experience, and years of experience in Women's Health. Four of the nurses were nurse practitioners (range of experience from 1-16 years); four had experience in instrument development (range of experience from 2-6 years); and, one of the nurses was an expert on lesbian health issues.

Table 1

Demographic Characteristics of Nurse Experts

n = 7

Characteristic	n	%
Present Employment Position*		
Women's Health Nurse Practitioner	3	42.86
Family Nurse Practitioner	1	14.29
Nursing Education	4	57.14
Nursing Administration	1	14.29
Highest Level of Nursing Education		
Bachelor's in Nursing	1	14.29
Master's in Nursing	4	57.14
Doctorate	2	28.58
Total Years of Nursing Experience		
10-19 years	3	42.86
20-29 years	2	28.58
≥30 years	2	28.58
Years of Experience in Women's Health		
5-15 years	5	71.43
16-25 years	2	28.58

*Add up to more than 100% because of inclusion in multiple categories

Content Validation

Table 2 displays the mean scores of descriptors on the critique questionnaire.

Table 2

Mean Scores of Descriptors on Expert Critique Questionnaire

Descriptor from the expert critique (not at all = 1.0; very much = 5)	$\bar{X}$
Completeness of health history form	4.64
Sensitivity to sexual orientation	4.76
Integration of the Shuler Nurse Practitioner Practice Model	4.64
Clarity of Part B	4.67*
Ability to accomplish a quality assessment, diagnosis, and plan of care that is sensitive to sexual orientation	4.93

*Six of the nurse experts responded to the question

The experts provided many suggestions to augment the health history form (Part A). For the General History section, suggestions included noting the type and source of medical care in the past year and environmental allergies. One nurse suggested including psychotherapy in the Medical History section. Two of the nurses commented that domestic violence and sexual abuse should be included in the medical history, and one nurse suggested drug and substance abuse should be included. In the Family History section, suggestions included adding alcohol and substance abuse, mental

health problems, rectal cancer, melanoma, and endometriosis. One of the nurses suggested age of family member with the history and whether living or dead should be included. Under Gynecological History, one nurse commented hysterscopy and dilatation and curettage should be included. Also, she recommended including in the "Yes/No" section: prior ectopics, spotting with sexual activity, and spotting or bleeding between periods. Under Contraceptive History, one nurse noted the sponge has been taken off the market and Norplant should be included.

One of the experts commented on the instrument's sensitivity to sexual orientation. She noted the instrument did not directly ask the patient about sexual orientation. The nurse stated this was "just fine, considering the conservatism of most medical settings".

Two of the nurses commented on the integration of the Shuler Nurse Practitioner Practice Model. One nurse noted "a practitioner would obviously need to read the Shuler-Davis articles to get acquainted with the terminology and background of the model to readily use the instrument". The other nurse noted the usual components of the psycho-social history (description of personal status, habits, home condition, and occupation) were "completely absent". Also, this nurse commented that three blank lines for subjective data gathering was inadequate, and that she personally would not use the nursing diagnosis.

All of the nurses agreed they would be able to accomplish a quality assessment, diagnosis, and plan of care that was sensitive to sexual orientation by using this instrument. Three of the nurse commented implementation of the instrument would be time consuming in actual practice. With the time constraints of patient appointments, these nurses questioned the practicality of the instrument.

One of the experts expressed the following concerns about the instrument and the critique questionnaire. First, she stated the label "instrument" should be omitted,

because instrument denotes measurement; the Nurse Practitioner Gynecologic Assessment Instrument is an assessment tool. Second, to be more consistent, the nurse suggested the critique should have included "descriptors for each model component". Third, credit to the Shuler Nurse Practitioner Practice Model should have been displayed on the instrument. Fourth, the instrument does not offer a section for follow-up evaluation.

Discussion

This project reflects the initial efforts of establishing content validity for the Nurse Practitioner Gynecologic Assessment Instrument. Though the nurse experts provided excellent suggestions, I wish to address six of the comments. First, due to the sensitive nature of the subjects, I debated whether to include substance abuse, sexual abuse, and domestic violence on Part A. At this time, I believe it is better for the provider to ask these questions in person, because the patient may not feel comfortable with ancillary personnel reading these answers during the screening process. Second, I omitted direct questioning of sexual orientation out of respect for those patients who do not want their sexual orientation documented in their medical record. Third, I also omitted the usual components of the psycho-social history due to the length of the instrument. Fourth, I developed a follow-up evaluation form but did not submit it for content validation. Fifth, I believe inclusion of a nursing diagnosis contributes to the holistic assessment of the patient. Sixth, I concur the instrument is time consuming and impractical in many practice settings, but integrating psycho-social, cultural, spiritual, occupational, and environmental components into an assessment requires time. It is a sad comment on the current structure of our health care system that providers are only allowed 15-30 minutes to perform a thorough health exam.

Chapter VI

Conclusion

This chapter contains the summary, identification of limitations, recommendations for future study, and implications for nursing.

Summary

The purpose of this project was to develop a gynecologic assessment instrument that was sensitive to sexual orientation. Through a review of the literature, the concept of lesbian identity and the problems lesbians encounter in accessing health care was explored. Heterosexist bias was found to be a major barrier in lesbians' quest for appropriate health care. A gynecologic instrument based on the Shuler Nurse Practitioner Practice Model was developed in an effort to decrease heterosexist bias during the gynecologic exam. To establish content validity of the Nurse Practitioner Gynecologic Assessment Instrument, seven nurse experts evaluated the instrument. The nurse experts provided excellent suggestions for this initial effort to establish content validity.

Identification of Limitations

At this time, the Nurse Practitioner Gynecologic Assessment Instrument can only be recommended for use in clinical practice. Because it is an assessment tool, its use as an instrument of measurement in research is questionable. In its current form, it would be impossible to test for construct and predictive validity. Major revisions would be needed before it was marketed as a research instrument.

Recommendations for Future Study

As this instrument is in the initial stages of development, specific recommendations for further study are directed at further development of the instrument. Refinement of the instrument, by incorporating the suggestions from the nurse experts, needs to occur. After modification, replication of the study, using a different panel of

nurse experts, should be accomplished.

The instrument also needs to be tested in clinical practice. A sample of nurse practitioners could evaluate the efficacy of the instrument in the assessment of patients. Test for interrater reliability could be accomplished through evaluating the formulated nursing diagnoses of two nurse practitioners who assess the same sample patients.

Implications for Nursing

Every nurse who delivers health care to women, delivers care to lesbians. For this reason, nurses should expand their knowledge concerning lesbian health care issues and evaluate possible homophobic attitudes. But, this is not enough. In order to provide optimal health care to all patients, nurses must confront their preconceived notions of what female patients need. In other words, nurses must confront heterosexist bias. Heterosexist bias is a major barrier precluding lesbians from disclosing their sexual orientation and, in turn, preventing them from receiving appropriate health care. It should be the nurse's responsibility to ascertain sexual orientation, not the lesbian's dilemma to disclose.

Nurses also have a responsibility to evaluate heterosexist bias in the structure of the health care facility they are affiliated with. One important area to assess is the health history form used at the facility. If the form contains heterosexist bias, lesbians are burdened with the decision to either disclose sexual orientation or to pass as a heterosexual. Also, if the health history form does not acknowledge diversity in sexual orientation, the provider may be more inclined to ask heterosexist questions during the assessment. Findings from the current project suggest the Nurse Practitioner Gynecologic Assessment Instrument is an appropriate tool for assisting the nurse practitioner in performing a gynecologic exam that is sensitive to sexual orientation.

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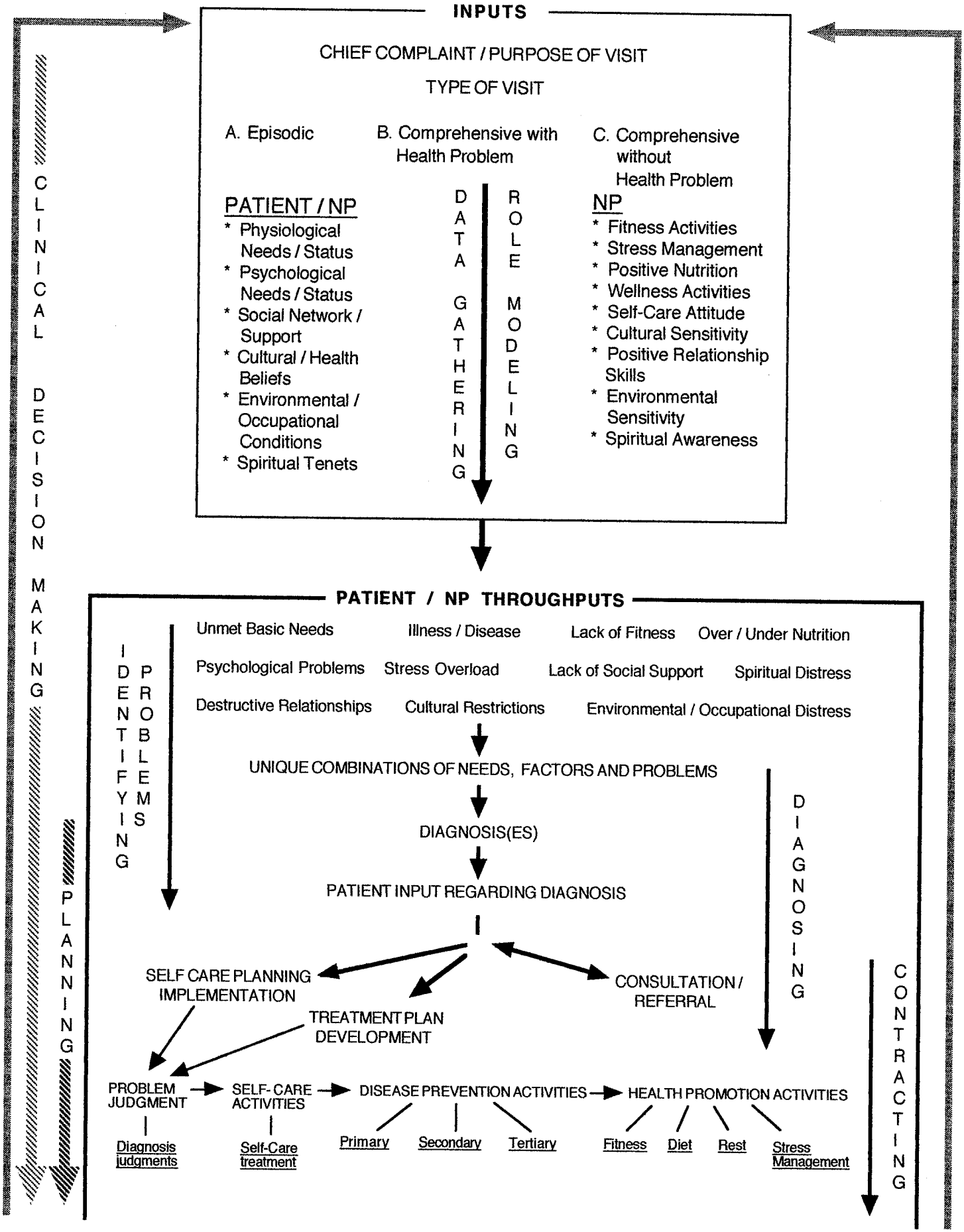
Appendix A

The Shuler Nurse Practitioner Practice Model

THE SHULER NURSE PRACTITIONER PRACTICE MODEL



IMPLEMENTATION

A. EPISODIC

1. How diagnosis made
2. Signs & symptoms of condition
3. How to know when to consult health care professional
4. How patient can make the diagnosis in the future

1. Prescribe treatment
2. Pharmacological tx component
3. Non-pharmacological tx component
4. How to follow treatment regimen
5. Possible reactions to treatment components
6. Preconsult home treatment

PRIMARY
1. Prevent spread of contagious condition
2. 1° preventive measures specific to condition

SECONDARY
1. How to detect recurrent problem in future
2. 2° preventive measures specific to condition

TERTIARY
1. Rehabilitative measures specific to condition

1. Health promotion activities related to the condition
2. Incorporate remainder of health promotion activities to strive for attainment of a higher health status

B. Comprehensive With An Existing Acute Problem

1. How diagnosis made
2. Signs & symptoms of condition
3. How to know when to consult health care professional
4. How patient can make the diagnosis in future

1. Prescribe treatment
2. Pharmacological tx component
3. Non-pharmacological tx component
4. How to follow treatment regimen
5. Possible reactions to treatment components
6. Preconsult home treatment

PRIMARY
1. 1° preventive measures related to condition
2. General 1° preventive measures

SECONDARY
1. How to detect recurrent problem in future
2. 2° preventive measures related to condition
3. General 2° preventive measures

TERTIARY
1. Rehabilitative measures specific to condition

2. Incorporate remainder of health promotion activities to strive for attainment of a higher health status

B. COMPREHENSIVE EXAM WITH AN EXISTING CHRONIC PROBLEM

1. Prescribe treatment
2. Pharmacological tx component
3. Non-pharmacological tx component
4. How to follow treatment regimen
5. Possible reactions to treatment components
6. Preconsult home treatment

PRIMARY
1. 1° preventive measures related to condition
2. General 1° preventive measures

SECONDARY
2. 2° preventive measures related to condition
3. General 2° preventive measures

TERTIARY
1. Rehabilitative measures specific to condition

1. Health promotion activities related to the condition
2. Incorporate remainder of health promotion activities to strive for attainment of a higher health status

C. COMPREHENSIVE EXAM WITHOUT AN EXISTING HEALTH PROBLEM

PRIMARY
1. General 1° preventive measures

SECONDARY
1. General 2° preventive measures

1. All health promotion activities that can assist in attainment of a higher health status

PATIENT OUTPUTS

Movement toward improved health status and wellness, including:

* attainment of basic needs;
* increasing ability to utilize self-care activities;
* setting nutritional goals & actions to meet goals;
* setting fitness goals & actions to meet goals;
* setting stress management goals & actions to meet goals;
* increasing ability to function in social and work roles;
* increasing cognizance of spiritual & cultural belief system;
* assessing environmental occupational conditions;
* increasing confidence regarding health care needs, treatments & wellness activities;
* improving compliance to the mutually agreed upon treatment plan;
* decreasing complications & exacerbations of acute/chronic health conditions;
* improving quality of life.

EVALUATING

NP OUTPUTS

Moving toward personal wellness, including:

* setting & moving toward own nutritional, fitness, spiritual, cultural, stress management, social, environmental & self-care goals.

Movement toward a professional wellness orientation including:

* role-modeling wellness behaviors;
* facilitating wellness behaviors & self-care activities within plan of care for patient.

Identification of professional learning needs including:

* patient education updates;
* new diagnostic testing options;
* new treatment modalities;
* alternative health care update;
* community resource update.

Appendix B

Permission Letter from Dr. Pamela Shuler

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Address Reply To:
Service Unit Director
PHS Indian Hospital

Refer To:

October 28, 1994

Patricia L. Dykstra, RNC, ARNP, BSN
491 NW 101
Warrensburg, MO 64093

Dear Patricia:

Thank you so much for your letter about the Shuler NP Model. It is so nice to hear from someone who has been able to utilize it. Your research project sounds very exciting and I would be honored if you used the Model as a theoretical and clinical guide. Specifically, I grant you permission to : 1) develop an assessment form based on the clinical application example delineated in Part II; 2) develop client and NP questionnaires based on the outcome criteria delineated in Part II; and 3) exhibit the paradigm, illustrated in Part I, in the project paper and presentation.

Good luck with your important work. I would greatly appreciate your feedback regarding application of the Model. Please let me know if I can be of further assistance.

Sincerely,

Pam Shuler, DNSc, CFNP, RN
Coordinator, Women's & Children's Services
Cherokee Indian Hospital
Cherokee, NC 28719

(704) 497-9163 EXT 377

Appendix C

The Nurse Practitioner Gynecologic Assessment Instrument

NURSE PRACTITIONER GYNECOLOGIC ASSESSMENT INSTRUMENT

PART A

Date_____

PLEASE PRINT

Date of Birth_____ Age_____

Name_____ Home Phone(___)_____ Best Time_____

Last First Middle Work Phone(___)_____ Best Time_____

Address_____ SSN or Patient ID #_____

Street City State Zip Can we identify ourselves if we call you? ___Yes___No

Please check all the ways we may contact you:__Call home __Call work __Write home (plain envelope)__Other_____

Emergency Contact Person:Name_____Relationship_____

Address_____ Phone(___)_____

Race:___White ___African American ___ Native American ___Asian ___Hispanic___Other_____

Do you have: ____Private insurance ____Medical assistance ____HMO ____Medicaid number:_____

Sources of income: ___Self ___Partner ___Spouse ___Parents ___Public assistance __Other_____

Total income from all sources_____ Number of persons supported by income__Number of school years completed____

Are you a student? __Yes __No.Place of employment_____.Received services at this clinic before? __Yes __No

Your private doctor(s)/clinic_____ City/State_____

You are here today because:_____

GENERAL HEALTH

Medical care in past year:_____Medications used in past year:_____

Hospitalizations/Surgeries Type/Dates: _____

Major illnesses Type/Dates:_____

Allergies (include drug and metals):_____Up to date on immunizations? __Yes __No__Unknown

Ever had a transfusion of blood?__Yes __No. Did your mom take DES while pregnant with you? __Yes __No __Unknown

Do you have a history of: ___Diabetes ___Thyroid disease ___High blood pressure ___Migraine Headache___Stroke

___Blood clot in veins ___Cancer ___Obesity ___Genetic problems___Sickle cell ___Jaundice/Hepatitis

__Other(specify)_____. How many cigarettes do you smoke per day?_____

How many servings of alcohol do you have per week?_____. How often do you use street drugs?_____

How often and for how long do you exercise?_____Type of exercise:_____

How many servings of the following do you eat/day? Fruits_____ Vegetables_____ Nuts/beans_____

Eggs/meats_____ Breads/cereals_____ Milk/dairy products_____ Coffee/tea/cola_____

FAMILY HISTORY

Indicate who in your birth family has the following (If adopted, disregard)

DISEASE	YES	NO	?	FAMILY MEMBER/COMMENTS
High blood pressure				
Heart disease				
Diabetes				
Breast, uterine, or ovarian cancer				
Cancer of any type				
Genetic problems				

MEDICAL HISTORY

Do you NOW or have you ever had:	YES	NO	?	Do you NOW or have you ever had:	YES	NO	?
Frequent or severe headaches				Nausea/vomiting, change in appetite			
Seizures/fainting/neurologic disorders				Swollen glands			
Vision problems				Gallbladder/liver disease/problems			
Difficulty swallowing				Kidney/bladder problems/infections			
Chest pain/difficulty breathing				Pain/burning or frequent urination			
Heart problems/murmurs				Difficulty holding urine			
Anemia/blood disorders				Rash or sores on skin			
Stomach/intestinal problems				Change in size or color of mole			
Frequency of diarrhea/constipation				Heat or cold intolerance			
Recent weight gain or loss				Numbness or tingling sensations			

GYNECOLOGICAL HISTORY

Have you ever had a pelvic exam? ____Yes ____No. Date of last Pap smear _____. Was it normal?____Yes____No
Have you ever had a mammogram? ____Yes ____No. Date of last mammogram_____
Gynecologic Surgeries: ____Laproscopy ____Colposcopy ____Laser surgery ____Cryosurgery ____ Hysterectomy
____Endometrial biopsy ____Ovarian cyst removal ____Breast biopsy ____Mastectomy ____Other_____

Do you NOW or have you ever had:	YES	NO	?	Do you NOW or have you ever had:	YES	NO	?
Breast disease/lump/nipple discharge				Rash, sores, or ulcers on genitals			
Frequent vaginal infections				New or changing mole on genitals			
Unusual discharge/odor				Pain/bleeding with sexual activity			
Lower abdominal pain or pressure				Uterine fibroids or abnormalities			
Fever/chills with abdominal pain				Hot flashes			
Infection of uterus, tubes, or ovaries				Dryness of vagina			
Chlamydia, Gonorrhea, herpes, warts,syphilis				History of infertility			

MENSTRUAL HISTORY

First day of last normal period_____. If menopausal, age of last period_____.Age when periods began_____
How often do you get your periods?_____. How many days do you bleed_____
Is your bleeding ___Light ____Medium_____Heavy. Severe menstrual cramps?____Yes ____No
Unusual or missed periods in past year?____Yes ____No. Premenstrual symptoms?____Yes ____No

CONTRACEPTIVE HISTORY

Type of birth control currently used:____None needed ____pill ____IUD___Depoprovera____Diaphragm____Condom
___SpongeFoam/creams/suppository/film ___Natural family planning ___Withdrawal ___Tubes tied ___vasectomy
How long have you used this method?_____. Problems?_____
Other methods used:_____. Problems?_____
Are you interested in discussing a method?_____. Do you plan to have children in the future___Yes ___No ___Unsure

PREGNANCY/PARENTING HISTORY

Date Preg. Ended	Number of Weeks	Vaginal or Cesarean	Abortion or Miscarriage	Type of Anesthesia	Complications with Pregnancy or Delivery

Age at first pregnancy:_____. Number of living children:_____. Are you pregnant now?___Yes___No___Unsure
Are you actively seeking to become a parent now?___Yes___No. By what method?___Artificial insemination__Adoption
___Conceiving with male partner___Foster parenting. Any problems with this method?_____

SEXUAL HISTORY

At what age did you become sexually active?_____.Are you currently sexually active___Yes___No. Do you engage in sexual activity with:__Men__Women__Both__Decline to answer at this time. Have you had more than one sex partner in the past six months?__Yes__No. Does your partner(s) have STD symptoms?__Yes__No. Do you know the HIV status of yourself and your partner(s)?__Yes__No__Unsure. Do you practice safe sex with your partner(s)?__Yes__No__Unsure.
Type of sexual activity__Oral__Vaginal__Anal. Do you have pain with sexual activity (Describe)?_____
Do you have any sexual concerns or problems you wish to discuss?_____

Assurance of Confidentiality: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

PROVIDER COMMENTS:

PART B

TYPE OF VISIT
__Episodic
__Comprehensive with an existing acute problem
__Comprehensive with an existing chronic problem
__Comprehensive without an existing health problem

Name:_____
Age:_____. SSN or Patient ID #:_____
Today's date:_____LNMP:_____

Gravida_____Para____ Miscarriages____Abortions_____Number of living children_____. Allergies_____
Current contraceptive method:_____. Education given __Yes__No__N/A.

Reason for Visit:_____

_____

_____ Staff Signature

_____

SUBJECTIVE DATA GATHERING (PROVIDER)

REASON FOR VISIT/HISTORY OF PRESENT ILLNESS

_____

_____

_____

Physiological Status/Needs (effects condition has on on fitness and/or sexual activities):_____

_____

Psychological Status/Needs (psychological response to condition and coping strategies):_____

_____

Social Support/Networks(response and support of family and friends):_____

_____

Cultural/Health Beliefs (beliefs regarding condition;current use of non-traditional treatments):_____

_____

Environmental/Occupational Conditions (ability to maintain responsibilities; environmental factors/hazards impeding recovery):___

_____

Spiritual Tenets (use of spiritual/religious healing practices; beliefs that may possibly impact treatment):_____

_____

PAST MEDICAL HISTORY

Psychological Status/Needs (also past alcohol or drug abuse):_____

_____

Cultural/ Health Beliefs:_____
Environmental/Occupational Conditions:_____
Spiritual Tenets:_____

FAMILY HISTORY

Psychological Status/Needs (family members with mental health problems; spousal/child abuse/incest):_____

_____

Social Support/Networks (presence or absence of "family support"): _____

_____

Cultural/Health Beliefs:_____
Environmental/Occupational Conditions:_____
Spiritual Tenets:_____

PERSONAL AND PSYCH-SOCIAL HISTORY

Physiological Status/Needs (sexual concerns ex. dyspareunia):_____

_____

Psychological Status/Needs (relationship with significant other; sexual concerns; domestic violence; "life view"):_____

_____

Social Support/Networks (Presence or absence of someone who cares/who can give tangible support):_____

_____

Cultural/Health Beliefs:_____
Environmental/Occupational Condition:_____
Spiritual Tenets:_____

OBJECTIVE DATA GATHERING

LABORATORY

Result	Int.		Done	Declined	Results
B/P		Pap			
HT		GC			
WT		Cervix			
HCT		Anus			
Chem strip 9		Throat			
U/A		Chlamydia			
Protein		Herpes			
Sugar		VDRL			
		Sickle Cell Testing			

MICROSCOPIC	
Vaginal	
KOH	
NaCl	
URINE	
RBC's	
WBC's	
Bacteria	
Nitrite	

PREGNANCY TESTS		
	Results	Initials
Early		
2 Minute Slide		

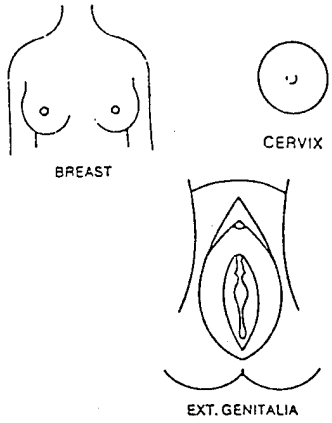
Hemoccult ☐ positive ☐ negative ☐ not done

OTHER

PHYSICAL EXAMINATION

	NORMAL	VARIANT	NOT DONE
1. HEENT			
2. Neck			
3. Heart			
4. Lungs			
5. Breasts			
6. Back			
7. Abdomen/Trunk			
8. Extremities			
9. Perineum/Vulva			
10. Vagina			
11. Cervix			
12. Uterus			
13. Adnexa			
14. Rectum			
15. Skin			

COMMENTS SELF-BREAST EXAM TAUGHT ☐ SUMMARY OF VARIANTS



DIAGNOSING

Identifying Problems (check applicable areas): __Unmet basic needs__Illness/Disease__Lack of fitness__Stress overload Over/under nutrition__Psychological problems__Lack of social support__Spiritual Distress__Destructive relationships __Cultural restrictions__Environmental/Occupational Distress __ Other_____

Unique Combination of Needs, Factors, and Problems:_____

Medical Diagnosis:_____

Nursing Diagnosis:_____

Patient Input:_____

TREATMENT PLAN

Consultation/Referrals:_____

Plan:_____

SELF-CARE PLANNING IMPLEMENTATION

Problem Judgment (Diagnosis judgment):_____

Self-Care Activities (Self-care treatment):_____

Disease Prevention Activities (Primary, secondary, tertiary):_____

Health Promotion Activities:_____

Follow-up Evaluation (Type and when):_____

Patient Input:_____

Patient and Provider Contract:_____

Literature/Education
(Staff initials by each piece of literature given to patient)

__HIV Assessment
__STD
__Vaginal Infection
__Fact Sheet
__Audio Visual
__Individual Instruction
__Contraception Sheet
__BSE __VSE
__Package Insert
__Medication Fact Sheet
__Parenting Issues
__Smoking
__Nutrition
__Stress Management
__Exercise
__Menopause
__Other_____

Appendix D

Cover Letter for Expert Panel for Content Validity

Dear Colleague;

Thank you for agreeing to participate as an expert to establish content validity of a newly developed instrument. I designed the Nurse Practitioner Gynecologic Assessment Instrument based on the Shuler Nurse Practitioner Practice Model (SNPPM). Also, I phrased questions in the health history to assist the nurse practitioner in performing an assessment that is sensitive to sexual orientation.

Please read the articles on the SNPPM and the article on sexual bias in language; examine the instrument; then, complete the critique and demographics questionnaire. The principle goal of this project is to ensure this instrument reflects the SNPPM and is sensitive to sexual orientation.

All questionnaires will be held in strict confidence. To assure anonymity, please DO NOT write your name on any of the pages. You may keep the articles but please mail the questionnaires in the enclosed stamped envelope by 30 September 1995.

Again, I am grateful your participation. Your comments are valuable. If you have any questions, please call me at 816-747-3050.

Sincerely,

Patricia L. Dykstra, R.N.C, A.R.N.P.,BSN
Graduate Student, Women's Health Nursing

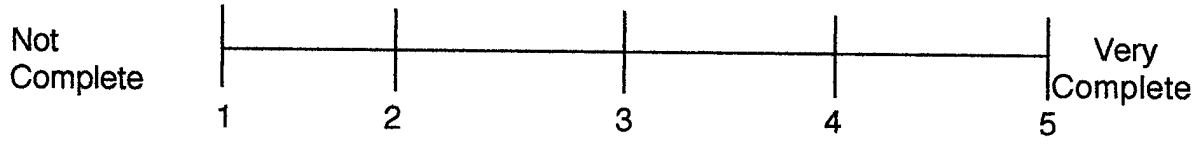
Appendix E

Critique Questionnaire for Content Validity

Instrument Critique by Expert Reviewers

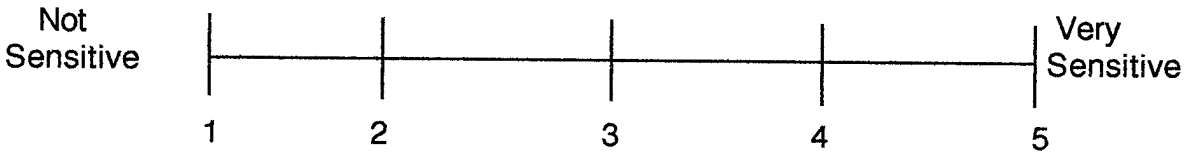
The following four questions refer to Part A only:

1. The standard history was based on Bates, B. (1991). A guide to physical examination and history taking (5th ed.) . Philadelphia: J. B. Lippincott. Is the health history complete?



2. What additional information is needed?

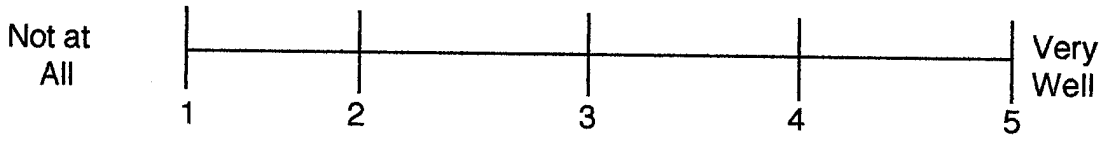
3. Is the instrument sensitive to sexual orientation?



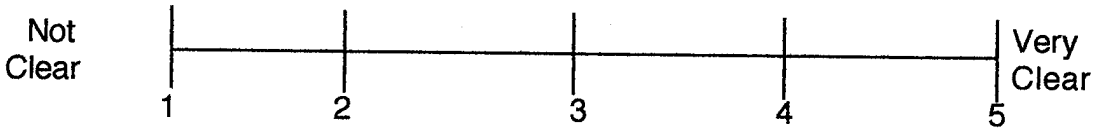
4. Additional comments or suggestions:

The following questions refer to Part B only:

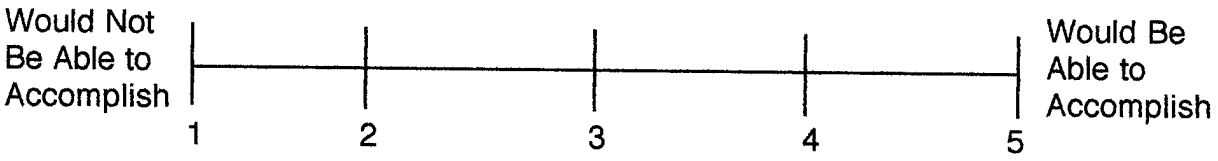
5. How well does the instrument integrate the Shuler Nurse Practitioner Practice Model?



6. Please rate the clarity of Part B.



7. Do you feel you would be able to accomplish a quality assessment, diagnosis, and plan of care that is sensitive to sexual orientation by using this instrument?



Additional Comments:

Appendix F

Demographic Characteristics of Nurse Experts

DEMOGRAPHIC QUESTIONNAIRE FOR EXPERT PANEL

1. PRESENT EMPLOYMENT POSITION: _____
2. YEARS OF EXPERIENCE IN THIS POSITION: _____
3. TOTAL YEARS OF NURSING EXPERIENCE: _____
4. YEARS OF EXPERIENCE WITH INSTRUMENT DEVELOPMENT: _____
5. YEARS OF EXPERIENCE IN WOMEN'S HEALTH:_____
6. HIGHEST LEVEL OF EDUCATION: _____